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ST PAUL CHIROPRACTIC

Automobile/PI Accident or Work Comp Questionnaire

Patient's Name ______________________ DOB ____________ HR#: ____________

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case as an automobile or work compensation case. For us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Please explain in detail how your accident happened.

____

____

What was the time and date of present injury? ______________________

Where did you feel pain immediately after the accident? ______________________

List the extent of your injuries as you know them: ______________________

____

____

Did you require post-accident hospitalization? Yes/ No (Check one)

Symptoms you have noticed since the accident (circle):

Headache	Dizziness	Depression	Fatigue
Light Bothers Eyes	Buzzing in Ears	Diarrhea	Neck Pain
Head Seems too Heavy	Memory Loss	Cold Feet	Stiff Neck
Pins and Needles in Arms	Ringing in Ears	Cold Hands	Fainting
Sleeping Problems	Back Pain	Flushed Face	Loss of Balance
Pins and Needles in Legs	Constipation	Tension	Nervousness
Numbness in Fingers	Loss of Smell	Fever	Irritability
Numbness in Toes	Loss of Taste	Chest Pain	Cold Sweats
Shortness of Breath	Stomach Upset		

Symptoms other than above:

____

Where were you taken after the accident? ______________________

Hospitalized? **Yes/ No** If yes, admitted? ____________ How long? ____________

Name of Hospital ______________________

Name of Doctors ______________________

What treatment was given? ______________________

Was any other doctor consulted after your accident? Yes/ No

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Patient's Name ______________________ **DOB** __________ **HR#:** __________

If so, what was the doctor's name?________________________ D.C., M.D., D.O., D.D.S.

What was the diagnosis? ____

What treatment was given? ____

How often did you see the doctor? ____

How long did you see the doctor? ____

Have you ever had any complaints in the involved area before? Yes/ No

If so, what were the complaints? ____

Before the injury were you capable of working on an equal basis with others your age? Yes/ No

Are your work activities restricted as a result of this accident? Yes/ No

Since this injury are your symptoms, Improving? Getting worse? Same?

Driver of other vehicle (if any): ________________________________

Name ______________________Insurance Company________________Policy No. _________

Driver of vehicle in which you were injured (if applicable)

Name______________________Insurance Company________________Policy No. _________

Name of your insurance adjustor ____

Have you retained an attorney? Yes/ No

If so, his/her name and address ______________________________

You were heading North/ East/ South/ West on __________________(street or highway)

Other vehicle was heading North/ East/ South/ West on ___________ (street or highway)

Were police notified? Yes/ No

Were you knocked unconscious? Yes/ No If so, for how long?

You were struck from Behind/ Front/ Left Side/ Right Side

You were Driver/ Passenger/ Front seat/ Back Seat/ Using seat belts

______________________ __________ __________
Patient's Name DOB HR#:

______________________ __________
Patient signature DATE

______________________ __________
Doctor signature DATE

INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at St. Paul Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

____________________________________ ____/____/____ Witness Initials
Patient or Authorized person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on____/____/____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

____________________________________ ____/____/____ Witness Initials
Patient or Authorized person's Signature Date